Child Intake Form

This is a comprehensive and confidential intake form that greatly assists in the understanding of your child's physical, mental, and emotional health both past and present. This information is necessary to properly assess your child and prepare an optimal treatment plan. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. You may consider copying it for your own future records.

General Contact Information

Name: ____
(Last name) (First name) (Middle initial)

Age: ___ Gender: Male Female Date of Birth: _______/_________/_______
D M Y

Address: ____
(Street) (Apt #)

____
(City) (Province) (Postal code)

Parent/Guardian Contact Information

Mother's: ______________________ ______________ ______________
(First & Last Name) (Home Phone) (Cell/Work Phone)

Father's: ______________________ ______________ ______________
(First & Last Name) (Home Phone) (Cell/Work Phone)

Primary Contact Person (circle): Mother / Father Primary Contact E-mail address: ____________________

Primary Contact phone number(s) we can leave messages related to your child's visit (Circle): Home / Work / Cell

How did you hear about the Dr. Irwin? Friend / Coworker / Internet / Health Care Provider / Health Food Store / Other: ___________

Personal Health Information

What are your child's most important health concerns/conditions? List as many as you can, in order of importance:

Concern/condition	Diagnosed by	Date

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated these health problems in your child? If you prefer, feel free to list these in chronological flow chart form on a separate page.

Which of the problems on the previous page are of most concern to you as a parent?

What expectations do you have for your child's visit to the clinic?

Has your child tried other conventional or alternative treatments? If so, what were they and what were the results?

Treatment	**Result**

Current Medical Information

Primary physician: (Name) (Phone #) (Last Visit)

Other health care provider: (Name) (Phone #) (Last Visit)

Other health care provider: (Name) (Phone #) (Last Visit)

Medications / Supplements

Current Medications (Please include any prescription or non-prescription medications as well as the dosage and frequency of use):

Prescription Meds	**Dose**	**Frequency**	**Non-Prescription Meds**	**Dose**	**Frequency**

Current Supplements (Please include all vitamins, herbs, or natural products as well as the dosage and frequency of use):

Supplement(s)	**Dose**	**Frequency**	**Supplement(s)**	**Dose**	**Frequency**

Allergies

Is your child sensitive or have allergies to any of the following (please specify):

Medications: ____

Foods: ____

Environment: ____

What happens when your child has an allergy attack? ______________________________

What types of allergy testing has your child had? Circle all that apply.

Scratch	Blood IgG Food	Blood IgE Inhalant/ Food	Intradermal
Kinesiology	Cytotoxic	Food Intolerance Testing	Electro-acupuncture (VEGA, MORA)

Past Medical History

Please list all surgeries, major injuries, accidents or emotional trauma that your child has sustained and the year in which they occurred:

Surgeries / Major Injuries / Accidents / Emotional Trauma **Date**

____

____

____

____

Past Medications/Supplements and their purpose:

Past Medication **Purpose** **Past Supplements** **Purpose**

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

How many times has your child been treated with antibiotics? _______

Which of the following illnesses and conditions have your child had (past or present)? Circle all that apply.

Rubella	Measles	Mumps	Chickenpox	Whooping Cough
Polio	Rheumatic Fever	Scarlet Fever	Roseola	Asthma
Anemia	Arthritis	Learning Disorder	Bleeding	Cancer
Colic	Heat Murmur	Mononucleosis	Injury (Serious)	Kidney Disease
Liver dz./ Jaundice	Overweight	Ulcers	Acne	Bed Wetting
Vomiting Spells	Diabetes	Hypoglycemia	Allergies	Cradle Cap
Eczema	Ear Infections	Tonsillitis	Headache	Pneumonia
Croup	Hypothyroid	Hyperthyroid	Strep Throat	Hyperactivity
Impetigo	Other:____________	Other:____________	Other:____________	

Family History

Are the child's parents (circle): Married / Common-law / Separated / Divorced
Please list approximate ages and health status of your immediate family.

Relationship **Age (Current / Deceased)** **Health Concerns / Cause Of Death**

Mother: ______________________________
Father: ______________________________
Sister(s): ______________________________
____
Brothers(s): ______________________________
____
Paternal Grandfather: ______________________________
Paternal Grandmother: ______________________________
Maternal Grandfather: ______________________________
Maternal Grandmother: ______________________________

Are there any medical conditions that run in your family? ______________________________

Has any blood relative had the following (Circle all that apply):

Anemia	Arthritis	Asthma	Birth Defects	Bleeding
Cancer	Diabetes	Eczema	Glaucoma	Gout
Hay Fever or allergies	Heart Attack or diseases	High Blood Pressure	Mental Illness	Seizure / Epilepsy
Sickle Cell Anemia	Stroke	Thyroid (Hyper / Hypo)	Tuberculosis	Other: __________

Prenatal History

Describe the mother's health during pregnancy with this child/infant/adolescent (circle all that apply):

Bleeding	Nausea	Toxemia of Pregnancy	Trauma / Injury Pre Birth	Emotional Stress
X-rays	High Blood Pressure	Drugs/Smoking/Alcohol	Prescription Medication	Other:

Mother's Age at delivery: ______ Term (circle): Full / Premature by ___ days / Late by ___ days

Was the pregnancy: Easy / Difficult Any Complications Yes / No. If yes, explain: ______________________________

Was the birth: Vaginal / C-section / Induced / Forceps / Anesthesia Used

Was the delivery: Easy / Difficult Any Complications with delivery: Yes / No. If yes explain: ______________________

Place of birth: Hospital / Clinic / Birth Center / Home / Other ____________________________

Feeding / Diet History

Breast Fed? Yes / No How long? _____________ Was it easy / difficult? ______________________________

Approximate Feeding Schedule: ______________________________

Formula Fed? ____ How long? ________________ Combined with Breast Milk? ______________________________

Types of formula used and response to each type if adverse:

Formula Type	**Response if adverse**	**Formula Type**	**Response if adverse**

Age solid foods began ___ What foods? __________________ Adverse reactions to solid foods: ________________________

How many meals does your child generally eat each day? 1 / 2 / 3 / More than 3

Where do you usually buy your food? ____________________ How much of your child's food is prepared by you? ________

List the primary foods included and excluded in your child's diet:

Foods Included	**Foods Excluded**

List any of the following and relative quantities eaten regularly by your child. Pop, caffeinated teas, highly seasoned foods, processed foods, refined foods and any food you suspect might be harmful to his/her health.

____

____

List any foods your child seems to crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods etc.) ____

List any foods your child refuses to eat: ____

Is your child thirsty? Yes / No Amount of liquid child drinks each day _______ Amount Plain Water _________

What temperature liquids does the child prefer to drink? Hot / Cold / Room Temperature

Are you satisfied with your child's diet the way it is now? Why or why not?

____

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? ____

Vaccination History

Check off any that your child has received:

Vaccine	✓	When	Boosters	✓	When	Describe any adverse reactions
DPT						
Diptheria						
Pertussis						
Tetanus			Tetanus Booster?			
Measles						
Mumps						
Rubella						
Polio			Within last 2 years?			
Hepatitis						
Hib						
Influenza			Last Flu Shot?			
Meningoc.						
Chickenpox						

Has your child been out of the country in the last two years? Yes / No When? _________ Where? _______________

Have you ever used homeopathics preventatively for infectious disease? ________________________________

Vision History

Has the child's eyes been checked? Yes / No Describe any vision problems: ___________________________

Dental Health

Current dentist: _______________________________________ Last dental check-up: __________________

Last cleaning: _________________ Any fillings? Yes / No Type? ________________________

Any trauma to the teeth or jaw? Location? ________________________ Child's teeth hot or cold sensitive? Yes / No

Any orthodontic work done (ie. Braces)? Yes / No Type? ________________________

Bowel / Urinary Habits

Frequency of stool ____ times per day, _____ times per week

Does your child have pain passing stool? If yes explain: ____

Have you ever been concerned about the bowl habit of your child? If yes explain: ______________________________

Any urinary symptoms that you are concerned about? If yes explain:____

Sleep Habits

Does your child have trouble falling asleep? Yes / No Does your child sleep through the night? Yes / No

What is there pattern of sleep? ____

Does your child wake up looking and acting refreshed? Yes / No

Does your child have recurring dreams or nightmares? Yes / No If yes what is the theme?

____

What position does your child sleep in? ___________________________________

General Status

How would you rate your child's general state of health? Excellent Good Average Fair Poor

Rate your child's energy level: low 1 2 3 4 5 6 7 8 9 10 high

Rate your child's stress level: low 1 2 3 4 5 6 7 8 9 10 high

Listed below are factors which may or may not influence your child's state of being. Please mark the appropriate box signifying their influence on your child in general if applicable.

Better	Worse	Factor
		Winter
		Spring
		Autumn
		Summer
		Cold
		Heat
		Dampness
		Storms
		Sun
		Wind
		Open Air
		Confined Stuffy Air
		Change of weather
		Moonlight
		Ocean Seashore
		Mountains

Better	Worse	Factor
		Physical Exertion
		Upon Rising
		Morning
		Afternoon
		Night
		Bath
		Cold Applications
		Warm Applications
		Travelling
		Touch
		Being Consoled
		Presence of Strangers
		Other:
		Other:
		Other:
		Other:

Please mark (1) = mild, (2) = moderate or (3) – severe next to the following symptoms which apply to your child NOW or in the PAST:

NOW	PAST	Symptoms
		Anxiety
		Restlessness
		Crying Spells
		Depression
		Despair / Discontent
		Mood Swings
		Suicidal Attempts
		Loneliness / Feel Alone
		Intimate with Others
		Prefer to be with Company
		Prefer to be alone / Don't Seek out Company
		Afraid when Alone
		Rather be alone when not feeling well.
		Other:

NOW	PAST	Symptoms
		Memory difficulty, forgetting
		Mental Confusion
		Decrease Concentration, Comprehension
		Make many mistakes
		Shy, timid
		Critical Of Self
		Critical of Others
		Lack of Self-confidence
		Suspicious / Jealous
		Sensitive to noises
		Organized, neat / clean
		Affectionate
		Assertive, powerful
		Confident, secure.

Child Development and Behavior

Is/was your child's physical development: Slower than Average / Average / Faster than Average

Teething: Early / Average / Late / Difficult Walking: Early / Average / Late Talking: Early / Average / Late

Mental / Emotional Development: Slower than Average / Average / Faster than Average

How is your child's behavior /attitude and performance at school? ____

How is your child's behavior/attitude and performance at home? ____

Describe your child's social interaction with:

Siblings: ____

Other Children: ____

Adults: ____

Strangers: ____

In a paragraph, write a short description of your child as he/she is currently. Include strengths, weaknesses, and major personality characteristics.

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Anger

What makes your child angry? ____

Does your child get angry often/easily? ____

Does your child experience uncontrollable rage? ____

Does your child have difficulty expressing anger? ____

How does your child express anger? ____

Sadness

What makes your child sad? ____________________

Does your child cry when sad? ____________________

Does your child cry easily/often? ____________________

Grief

List major experiences of grief/loss in your child's life:

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____

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Fears

Is your child fearful of anything such as animals, snakes rodents, people, being alone, robbers, ghosts, sudden noise, thunder, the unknown, heights, closed spaces, failure of doing new things, speaking in front of class, being thrown up in the air and caught, falling, etc? Are any unmanageable?

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Other Comments

Is there anything that you feel is important about your child that has not been covered?

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Thanks for taking the time to complete this intake form! The answers you provide allow us to have a better understanding of your child and what your main goals and health concerns are. ***Please fax, mail, or e-mail this form to the Marda Loop Naturopathic and Wellness Clinic at least 48 hours before your appointment to ensure we have time to go over what you have written and make the most of your child's initial visit.*** If sending a copy via e-mail please send to: *patientcare@mardaloopwellness.com*.